



**Delaware Health and Social Services
Division of Management Services**

Information Resource Management

Biggs Data Center

1901 N. DuPont Highway

New Castle, DE 19720

302-255- 9150 Fax 302-661-7213

**Biggs Data Center
User Authorization Form**

Transferring From:

Transferring To:

Department: _____

Department: _____

Division: _____

Division: _____

Unit/Section: _____

Unit/Section: _____

Employee Type: ☐ State ☐ Non-State ☐ FTE Contractor

☐ User Add

☐ User Delete

☐ User Update

☐ Temporary Access Only

Logon ID: _____ Effective Date: _____

Last Name _____
Title _____
Requester's E-mail _____
Supv's Name (Printed) _____
Company Name _____

First Name _____
Location w/Rm # _____
Phone # _____
Fax # _____
Birthday _____

Client Server Applications

Department	DPH	DMS
<input type="checkbox"/> OMS	<input type="checkbox"/> LIMS	<input type="checkbox"/> ACAMS
<input type="checkbox"/> MCI - SI	<input type="checkbox"/> EDIN	<input type="checkbox"/> DOLARS
<input type="checkbox"/> MCI - SI (Profile)	<input type="checkbox"/> ICAT	<input type="checkbox"/> ADL
<input type="checkbox"/> PMTS	<input type="checkbox"/> CHCIS	<input type="checkbox"/> Appl Tracking
<input type="checkbox"/> CMS	<input type="checkbox"/> NSP	<input type="checkbox"/> Court Cost
<input type="checkbox"/> HRMS/LT/TAS	<input type="checkbox"/> ISIS	<input type="checkbox"/> OAS
<input type="checkbox"/> KRONOS		<input type="checkbox"/> RPTS
<input type="checkbox"/> CATS	DSSC	<input type="checkbox"/> ADL/MDS
<input type="checkbox"/> Inventory	<input type="checkbox"/> CAPS	<input type="checkbox"/> Sched Optimizer
<input type="checkbox"/> Helpdesk	<input type="checkbox"/> AAF	
<input type="checkbox"/> EBT		DDDS
<input type="checkbox"/> TSO	OCME	<input type="checkbox"/> Client Registry
	<input type="checkbox"/> MES	
DSAMH	<input type="checkbox"/> Laboratory	DLTCRP
<input type="checkbox"/> Datamart	DVI	<input type="checkbox"/> IRC
<input type="checkbox"/> CIM	<input type="checkbox"/> ILS Client Mgmt	<input type="checkbox"/> AAR
<input type="checkbox"/> PMIS	<input type="checkbox"/> OASYS	<input type="checkbox"/> CBC
<input type="checkbox"/> SBI	<input type="checkbox"/> DVI Client Regis	<input type="checkbox"/> LCS
<input type="checkbox"/> Pharmacy		<input type="checkbox"/> FAC

Mainframe Applications

DPH	DCSE	DSS
<input type="checkbox"/> Vital Statistics	<input type="checkbox"/> DACSES	<input type="checkbox"/> E&T
<input type="checkbox"/> VacAttack		<input type="checkbox"/> DCIS
<input type="checkbox"/> WIC		<input type="checkbox"/> DCIS II
		<input type="checkbox"/> MMIS
		<input type="checkbox"/> CCMIS
		<input type="checkbox"/> ATLANTES
		<input type="checkbox"/> TAP/LTC
		<input type="checkbox"/> OTHER

Access Resources

<input type="checkbox"/> State Domain
<input type="checkbox"/> Citrix Secured Gateway/Application Domain
<input type="checkbox"/> SFTP/Application Domain
<input type="checkbox"/> Fleet Services
<input type="checkbox"/> Employee Badge Yes / No # _____
<input type="checkbox"/> Supercard
<input type="checkbox"/> Blackberry
<input type="checkbox"/> Air Card # _____
<input type="checkbox"/> Cell Phone # _____
<input type="checkbox"/> Pager # _____
<input type="checkbox"/> 800 # Authorization Yes / No

Dover

(Additional Forms Required)

☐ DFMS ☐ DOLP ☐ MTRV
☐ JICP ☐ DTI NET ☐ PHRST
☐ DELJIS ☐ DTI VPN ☐ CORP

DB2 Inquiry

☐ CCMIS ☐ CHCIS ☐ WIC
☐ DCIS II ☐ ACSES

☐ MMIS _____
Clerk Name Update #

☐ SSL VPN
IP Address of Destination: _____
Desired Protocol & Port: _____
Home Address: _____
Home Phone #: _____

DDDS #: _____

Purser Signature: _____

EMPLOYEE STATEMENT: I Certify that I will not access, use, or disclose any information available or acquired from the Department of Health and Social Services systems, except for purposes directly related to my job responsibilities. I have read and agree to adhere to the State Network Acceptable Use Policy, the DHSS Policy Memoranda Number 03 (E-mail), Number 05 (Confidentiality Agreement), and Number 10 (Internet). I have signed and understand the Biggs Data Center Non-Disclosure Agreement. A copy of the signed agreement is attached.

Employee Signature: _____ Date: _____ ACFM Admin: _____ Date: _____

Supervisor Signature: _____ Date: _____ Implemented by: _____ Date: _____